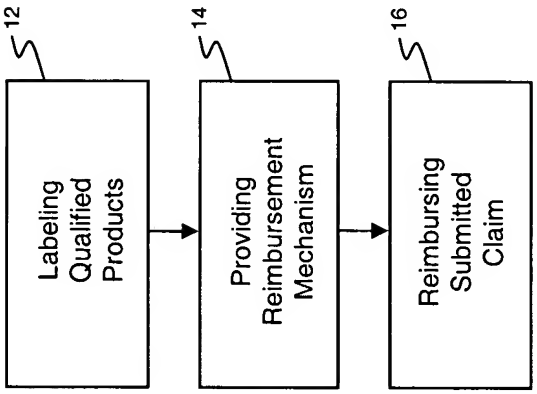
FIG. 1


12
Labeling Qualified Products
14
Providing Reimbursement Mechanism
16
Reimbursing Submitted Claim

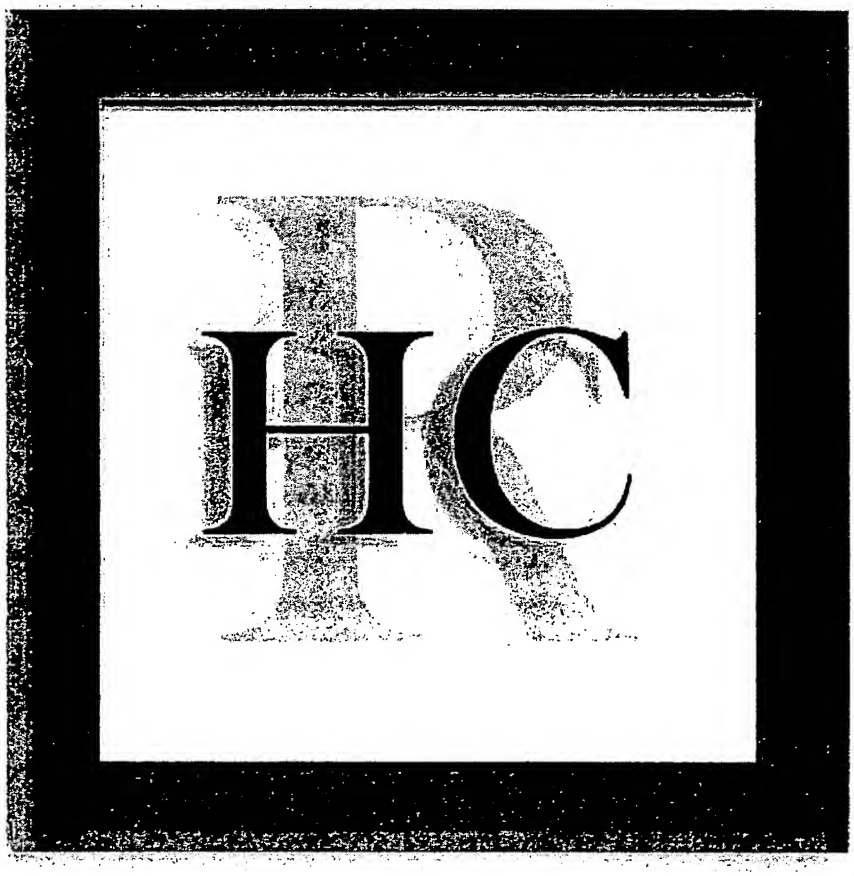


FIG. 2A

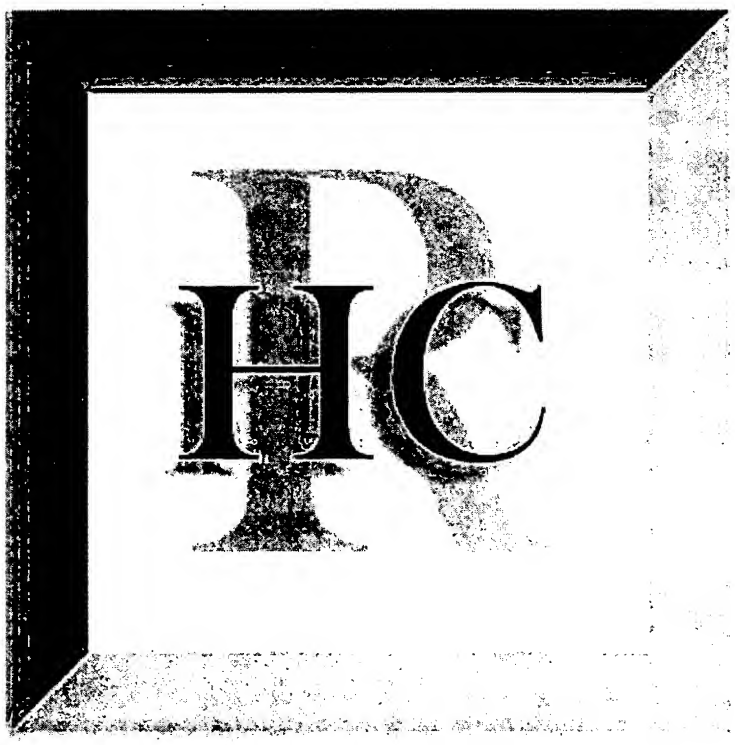
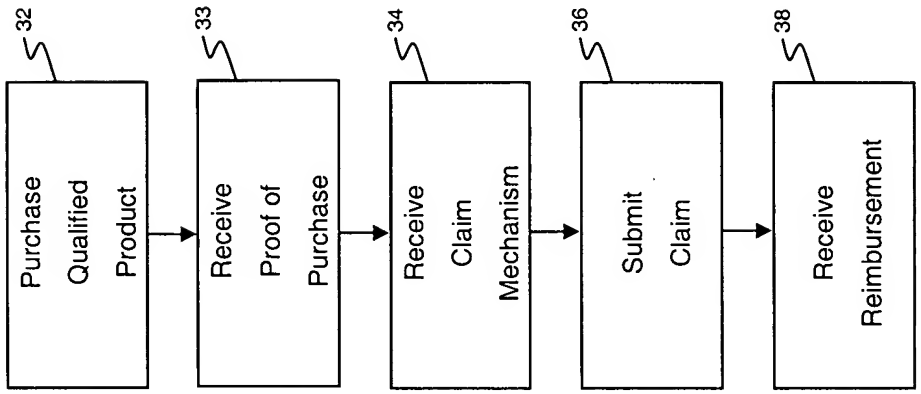


FIG. 2B

FIG. 3


32
Purchase Qualified Product
33
Receive Proof of Purchase
34
Receive Claim Mechanism
36
Submit Claim
38
Receive Reimbursement

SUBMIT CLAIMS BY:

FAX: (Preferred Method) 1-800-333-4444

MAIL: Claims Reception
P.O. Box 12345
Anytown, USA 12345

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Please Place STAMP Here

HC

Health Care Reimbursement Account Claims

(for you and your tax-qualified dependents)

How to Prepare Your Claim Form

Step 1 - Complete all employee and expense information. This form is processed electronically.

Step 2 - Sign and date the form. Be sure to read the certification information before signing.

Step 3 - Submit the completed claim form with any and all original documentation to The Plan Recordkeeper by fax (preferred method) or by mail, as stated above.

Employee Information (PLEASE PRINT)

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Name	Employer Name	Division

Address (Number & Street)	Email Address (Your email address will allow you to receive electronic notification)

City	State	Zip	Daytime Phone No.

Social Security Number

Instructions

Please use blue or black ink and print like this 0 1 2 3 4 5 6

For the amount entered in he space provided to be reimbursed, receipt documentation is required.

REIMBURSEMENT AMOUNT
Dollars Cents

If an amount is not entered here, the manufacturer's wholesale price will be used.

Total Expenses $

EXAMPLE: $ 13.28

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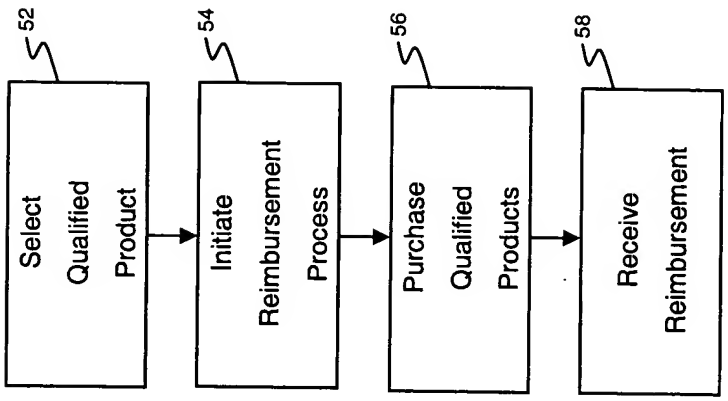
I certify that I have incurred this eligible expense. This expense has not been reimbursed prior to this submission and is not reimbursable from any other source. This over-the-counter (OTC) expense was incurred for medical care. I agree it is my responsibility to return any duplicate reimbursement received from any other source to my account, c/o The Plan Recordkeeper, Banking Department. I agree I am responsible for any and all bank, savings, or checking account charges that I incur. I agree to indemnify and hold harmless the Recordkeeper or Plan Administrator from any responsibility relative to my credit status. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read all printed material describing this program inclusive of the Summary Plan Description and all administrative materials defining the operation of this plan. I certify that I am responsible for compliance with all applicable administrative processes, tax regulations, and documentation. I will keep a copy of this form and all original receipts.

Participant Signature *Date*

FIG. 4

FIG. 5


52
Select Qualified Product
54
Initiate Reimbursement Process
56
Purchase Qualified Products
58
Receive Reimbursement